DOCUMENT RESUME

ED 238 238 EC 161 155

AUTHOR Rohde, Marjorie
TITLE Psychological Assessment in Developmental Disabilities.
PUB DATE 83
NOTE 20p.; Paper presented at the Conference of the American Association on Mental Deficiency (107th, Dallas, TX, May 29-June 2, 1983).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Descriptive (141)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Developmental Disabilities; Elementary Secondary Education; *Evaluation Methods; Models; *Psychological Evaluation; Rehabilitation; Screening Tests; *Student Evaluation

ABSTRACT

Research is cited to corroborate the lack of conceptual models for building a functional psychological evaluation system for developmentally disabled persons. A model is proposed for individualized evaluation/assessment using a functional approach and based on the cognitive-behavioral perspective. The model can be used to determine directions in service plan delivery. Assessment is differentiated from evaluation. Guidelines are offered for six stages in the psychological assessment process (sample subtopics in parentheses): screening (reason for referral); evaluation (evaluation of competencies and incompetencies for Individualized Service Plan); assessment (diagnostic considerations, identification of additional services); program plan and design (goal oriented statements); curriculum development (educational, vocational, self-help, recreational); and program implementation (inservice and staff development). A concluding section provides background information and clinical observations about psychological assessment of intellectual functions, affective disorders, physical and behavioral disorders, and the role of assessment as an integral part of the treatment process. (CL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

ED238238

PSYCHOLOGICAL ASSESSMENT IN DEVELOPMENTAL DISABILITIES

Marjorie Rohde, Ed.M., Ph.D. (ABD Status)
Doctoral Candidate
Boston College
Graduate School of Arts and Sciences
Department of Education
Division of Special Education and Rehabilitation
Chestnut Hill, Massachusetts

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Marjorie Rohde
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

SUMMARY

In order to advocate total-life experience training for the developmentally disabled person, it is important to assess the individual's personal and social adaptive skills and needs associated with coping and enjoying one's total environment. Evaluation and assessment consists of identifying life-skills suited to individual needs and learning styles in the natural setting. Treatment plans, emanating from the evaluative process, should contain built-in conditions which replicate those in this setting. Rehabilitation is based on a detailed assessment of physical impairments coupled with a realistic appraisal of potentials. Assessments should be related to the disability (stable or progressive), to intellectual functions and educational achievements, to social and economic backgrounds, and to the environment from which they have come and to which they will be returning.

EC161155

Whenever possible, it becomes a documentation of measurable changes in behavior. Hence, the problem-oriented statement containing behavioral objectives becomes an integral part of the process.

Valid assessment measures are not yet available for the developmentally disabled person. Usually a battery of tests and/or scales are selected, the choice depending on many variables, not the least of which is the experience and expertise of the examiner. Most instruments currently being used (e.g. WAIS, WISC, Vineland) have not been standardized on this group, which has defied definition until the 1978 legislation further clarified what is meant by "developmentally disabled." The results of evaluations have been only approximations of the subject's learning and performance capacities, and the resultant treatment plan has often been inappropriate and restrictive.

A conceptual model will be presented for the individualized evaluation/assessment, using a functional approach and based on the cognitive-behavioral perspective. It is hypothesized that with a valid system quality of care will occur, regardless of the etiology of the impairments. A secondary gain will be a reliable system of measuring outcomes during the re/habilitation process. Thus, a more effective method for identifying treatment goals and objectives will be created.

A literature review clearly establishes the lack of a conceptual model upon which to base a functional evaluation system. The model proposed here is one which views behaviors as overt indicators of adjustment and maladjustment, of internal strivings and of distorted

attitudes. The cognitive-behavioral perspective views behavior in a comprehensive way by combining both the internal (organismic) and environmental factors. The psychologist is viewed as a member of a team which commits itself to an honest and holistic appreciation of the uniqueness of each human being.

****

Psychological assessment (or the lack of it) of the developmentally disabled person living in the community seems to be at the core of many problems facing the service-provider. In a study conducted by the Rand Corporation at the request of the U.S. Department of Health, Education, and Welfare (Brever & Kakalik, 1979) questions were raised concerning the needs of handicapped children and the generalization of these needs to the handicapped adult population. The authors pointed out that the reasons why the care and services provided to handicapped youth are deficient in many important ways cannot be blamed on the inadequacy of funds, although more money would certainly help. They explain that resource insufficiency alone is not the answer to a basic problem that we find pervading nearly all aspects of the system. Service-delivery is complex and disorganized. However, not all problems are going to be solved by pouring more money into the "system" without doing something about its disorganization and complexity. Direction is defined by the authors as the periodic and systematic matching of a child's needs with the proper mix of available services to satisfy those needs. Direction is viewed here as an immediate outgrowth of an adequate and efficient assessment process, and effective implementation is related to availability of services.

The current service-delivery system in Massachusetts features the Individualized Service Plan (ISP) in an attempt to meet the needs of people with multiple impairments, especially Class Members who have resided in institutions for the mentally retarded client. Many, but not all, of these persons qualify for services as "developmentally disabled" because their primary diagnosis of mental retardation falls

within the legislative criteria for developmental disabilities (Public Law 94-103).

Direction is not always a central concern, or a result, of the ISP process, but occurs only tangentially to it. If an assessment team is inclined to evaluate the client's needs, and, as a result, to search out appropriate services and monitor the results, then direction becomes the team's primary concern. However, this is not always the outcome in all ISP's. Putting the pieces together is what direction is all about (Brewer & Kakalik, 1979). The psychologist is the one person on the legal service plan team who has the skills for evaluating the subject as a total human being. The urgent need for us to become more client-centered and less specialty-centered in the quest for direction in service-delivery with the developmentally disabled person faces the service system. Specialization, fragmentation and bureaucratization without coordination underlie poor systems performance and misdirection, according to these authors. Assessment is considered here as a technique for overcoming such issues.

Until Federal legislation began to focus on the needs of the individual with a developmental disability, treatment and management techniques were primarily oriented to group needs and group outcomes. For the most part, this developmentally disabled population was not considered appropriate or eligible for rehabilitation programs because economic self-sufficiency was not a realistic goal. Those residing in institutions were receiving limited educational programs and psychological interventions for assaultive and/or abusive behaviors. A goal-oriented management plan based on the individual's capacity for

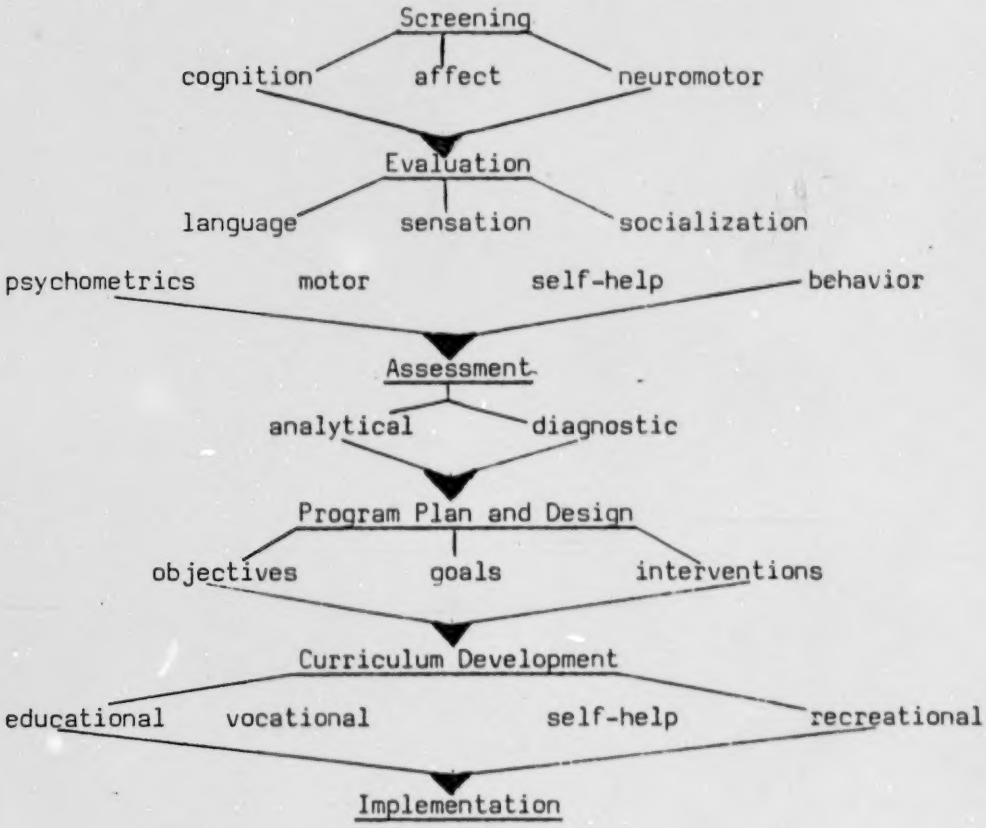
adaptation and learning did not exist. With the advent of the Individual Service Plan, needs of the individual became determining variables in treatment and management. The team approach gradually reached into the community programs as de-institutionalization proceeded. Specializations began to emerge within the various disciplines, each competing for their roles, and with this trend came greater emphasis on the client. The psychologist, on the other hand, was not prepared to meet the demands of this comprehensive approach. The traditionally trained clinician asked that their subjects verbalize their feelings and thoughts, and to physically perform tasks. Tests had been standardized on middle-class educated people who were free of functional impairments. These tests measured achievement in stimulating environments which were quite inaccessible to those with developmental handicaps. The psychologist had limited instruments for measuring the abilities and competencies of these people. Perhaps no subspecialty in psychology has had more impact on treatment direction than neuropsychology. Comprehensiveness and management characterized neuropsychologists' assessments. These seemed more compatible with Federal guidelines.

According to Lezak (1976), emphasis in clinical neuropsychology has been on assessing behavioral change and has evolved in response to practical problems of assessment and rehabilitation of brain-damaged patients. Because of unknown etiologies in developmental disorders and the chronicity of these impairments, for clinical purposes, it appears more advantageous for the patient to view themselves as having unidentified neurological disorders which are more effectively

evaluated through observations of the patient's idiosyncratic behaviors. The historical development of child neuropsychology has grown hand-in-hand with advances in the study of mental retardation, learning disabilities and children's behavior problems, according to this author. Behavioral observations have become key ingredients to the assessment process.

Direction in treatment has been finally recognized as the raison d'etre for the psychologist's assessment. Psychotherapeutic techniques have begun to include behavioral approaches which have opened many avenues to the clinician faced with a non-verbal mentally retarded and physically impaired person. In conjunction with these trends has been the appreciation for the covert world of the non-verbal client. In practice, the major limitation has been the void created by the absence of guidelines for psychological assessments. The purpose of this paper is to share a model which has evolved over several years, in and out of the institutional environment, and which has proven to be practical and effective for determining directions in service plan delivery. The focus is the patient, not the environment, and their needs, which determine the character of the final input. This writer has been unable to verify that such a model for psychology exists, a model which is flexible and dynamic and links intake to the final treatment phases. In utilizing this comprehensive outline, the psychologist provides a backup to others involved in service delivery as well as to the patient. It is significant to note here that the developmentally disabled person has not always been perceived as someone who has emotional needs and strivings, and

services were traditionally identified in accordance with the resources available rather than by the client's needs. Recent years have also seen advancements in evaluation tools which yield greater reliability and validity in results.



Annual Review Process in Psychology

Sometimes there exists confusion between the terms evaluation and assessment even though in some instances these terms may be interchangeable. The distinction made here is between the current status of the client (evaluation) and the change in a patient's status over time (assessment). The evaluation is viewed as a comment on the person's achievement; the assessment is viewed as an indicator of potential behaviors. The assessment in this context mandates an analysis of the client's historical records in order to elicit behavioral patterns which might be followed in the future. This approach is reflected in the Process chart on the previous page by locating the assessment phase after the major categories of psychological behaviors have been investigated. The assessment then evolves into an ongoing process which continues over time and may eventually provide longitudinal data (Rohde, 1979).

The following guidelines grew out of the Annual Review Process because of the need to provide structure to the inexperienced psychologist and to standardize the technique for referrals. The basic concept offers a broad-based foundation, like a pyramid, from which all future decisions are made. Hence, unless this foundation is created, the rest of the structure will eventually be meaningless as the psychologist proceeds toward the final phases of treatment implementation, at the peak of the pyramid. Each phase of the operation, therefore, subsumes the previous phases.

Guidelines for the Psychological Assessment Process

I. Screening

1. Ascertain whether client is appropriate for further investigation on the basis of the following information:
   a) Cognition: level of I.Q.; range of mental retardation
   b) Affect: history and/or presence of emotional disturbance
   c) Motor: history and/or presence of functional impairments
   d) Age
   e) Reason for referral: statement of problem
   f) Identify areas for further examination

II. Evaluation

1. Examine current abilities with appropriate psychological instruments:
   a) Language
   b) Intelligence and learning style
   c) Sensation
   d) Socialization and behaviors
   e) Self-help
   f) Motor
2. Evaluate competencies and incompetencies for Individualized Service Plan
3. Recommendations based on competencies

III. Assessment

1. Analyze information contained in evaluation:
   a) Extent of disability and/or impairment
   b) Educational background
   c) Aptitudes and interests
   d) Personality
   e) Social/family history
   f) Occupational history
   g) Medical history
2. Diagnostic considerations (variables effecting behavior):
   a) Presence of affective disorders
   b) Presence of learning disability
   c) Presence of developmental delays
   d) Presence of organic mental disorders
   e) Presence of neurological disorders
   f) Presence of mental retardation
3. Additional evaluative procedures:
   a) Visual-motor tests
   b) Projective instruments
   c) Task-oriented instruments
   d) Academic achievement tests
4. Identify additional services needed for:
   a) Skill acquisition
   b) Resolving existing medical problems

4. c) Least restrictive environments

   d) Diagnostic issues

5. Establish eligibility as Developmentally Disabled:

   a) Presence of mental retardation, or blindness, or deafness, or seizures, or multiple physical disabilities, or cerebral palsy, or autism

   b) Presence of substantial handicap to employment caused by functional limitations

   c) Incapable of self-maintenance because of functional deficits

6. Summary statement geared to a consideration of services directed toward the alleviation of the developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of the person (P.L. 94-103) by means of interventions and environmental manipulation to maximize learning appropriate to life style and developmental stages of that person from a psychological viewpoint

IV. Program Plan

1. Consideration given to intellectual functions:

a) Receptive

b) Memory and learning

c) Cognition

d) Expressive

e) Mental activity

2. Goal-oriented statements in behavioral terms for psychological need areas with objectives, recommended types of interventions, and settings for programming

3. Recommendations for staff assignments

V. Curriculum

1. Behavioral assessment of need areas to include:

a) Frequency of behavior

b) Duration of target behavior

c) Antecedents to target behavior

d) Consequences to target behavior

e) Incidents of target behavior

2. Translating Program Plan into behavioral terms easily understood by family or staff

VI. Program Implementation

1. Inservice and staff development

2. Monitoring of client progress

Intervoven into this approach is a respect for the cognitive-learning perspective in psychotherapy (Mahoney, 1977). This causal circularity viewpoint presumes the existence of a continual working relationship and interaction between the human being and their environment. The author has discussed trends in contemporary psychology, pointing out three directions in the movement: 1) behavior therapy, 2) existential-gestalt, 3) eclecticism. Eclecticism, which embodies ideological and technological flexibility, offers the most integrative approach, and attempts to interface behavioral approaches with cognitive and affective interpersonal processes, in the diagnosis and treatment of those with developmental disabilities. Determinants of human behavior are here viewed as both internal and external to the person by recognizing the significance of private and intrapersonal events as well as environmental events in adaptation and adjustment processes.

The utilization of these guidelines in a program servicing the mentally retarded and developmentally disabled (MR/DD) population residing in a metropolitan catchment area (Boston) has provided this writer with the myriad frustrations and self-examinations which seem inherent to the growth process. The final product emanating from my desk reflects in concrete terms not only the current state-of-the-art but the built-in resistances to change. However, the client's problems do not go away because the Zeitgeist may be absent. Problem-solving needs more than ingenuity and committment; it requires a willingness to find solutions and the perseverance to defend them. Most programs are so heavily loaded with political issues that the human issues become lost in a sea of funding, equipment, buildings, transportation,

etc.

The format for psychological reports currently being used in the Boston program has combined the Screening, Evaluation and Assessment phases into one stage by providing information on the cognitive and adaptive behavior functioning levels of the client. Some background information and clinical observations are also included.

Issues and Implications.

1. Intellectual functions. All tests used have not been standardized on the MR/DD population, creating controversy over the validity of reporting quotients (eligibility for service mandates the quantification of "intelligence"), and raising philosophical questions of "group norms" versus "criterion referenced" approaches. Variance in reporting, by psychologists, is the consequence, and has resulted in a lack of consistency and standardization, with agency needs taking priority over client needs (i.e. a non-retarded person with verbal skills may receive counseling and inflate the agency's census).

2. Affective disorders. This issue is usually omitted from reports because of the reluctance by most psychologists to attempt differential diagnosis on the MR/DD client who may not only have a history of psychosis which has responded to drug therapy, but may also be exhibiting behaviors characteristic of a new disorder. There is still a lot of controversy among psychiatrists and psychologists over the benefit of psychotherapy to this population. The DSM-III (1980) contains criteria for the major affective disorders encountered in these clients (e.g. developmental delays, organic mental disorders, learning disabilities). Some authors also believe that standard inter-

pretation of data obtained on a diagnostic test, designed for the rehabilitation sample, and developed and designed to assess a psychiatric population, opposes every principle of sound assessment, but the lack of more relevant tools has created this dilemma. No problem-oriented record has as yet been developed that can adequately handle the many psychological and social problems that affect the client's physical and rehabilitative state. Currently used ADL checklists limit their focus to explicit behavioral acts rather than emotions and attitudes which may covary and influence them (Millon et al, 1982).

3. Physical and behavioral disorders. Among the currently used assessment instruments in rehabilitation psychology is the problem-oriented type of record which identifies the subject's physical disabilities and provides objective and standardized profiles for systematically comparing each component of the rehabilitative process (Weed, 1969). A new series of behavioral and physical measures have been developed as rehabilitation indicators (RIs) and include information which come from behavioral observables. They are multidimensional in scope, including status, activity-pattern, skill, and environmental indicators. Because these RIs omit emotional and personological data, assessment utility is limited to the psychodiagnostician (Millon et al, 1982). Such limited use has reinforced the already wide gap existing among the various disciplines, and deprives the client of services based on needs.

4. Assessments as integral part of treatment process. Much progress has taken place as a result of the Federal regulations mandating evaluations prior to making treatment recommendations (e.g.,

status assessments and problem-oriented objectives on the ISP or IEP). Until those in administrative positions can be persuaded of the cost-effectiveness of such an approach, the symptomatic model will continue to dominate, eliminating the use of thorough assessment procedures in the clinical fields. Understanding the implications of conditions and disorders by documenting changes over time will also be limited until the appreciation of assessment procedures' contributions to this understanding takes place.

The understanding of the psychological reactions to physical and mental disabilities requires the understanding of human beings in all their complexity, according to Shontz (1977). No assessment can be expected to examine all aspects of the individual's complex nature. However, much of the evaluative outcome depends on the psychologist's ability to bring their own insights into the investigation. Having access to a format has served this writer in assuring thoroughness, uniformity, and appropriateness of the final result.

REFERENCES

Brever, G. D. & Kakalik, J. S. Handicapped children: strategies for improving services. New York: McGraw-Hill, 1979.

Diagnostic and statistical manual of mental disorders (DSM-III). Washington: American Psychiatric Association, 1980.

Lezak, M. D. Neuropsychological assessment. New York: Oxford University Press, 1976.

Mahoney, M. J. Reflections on the cognitive-learning trend in psychotherapy. American Psychologist, 1977, 32, 1, 5-13.

Millon, T., Green, C. J. & Meagher, Jr., R. B. A new psychodiagnostic tool for clients in rehabilitation settings: the MBHI. Rehabilitation Psychology, 1982, 27, 1, 23-35.

Rohde, M. S. Psychological assessment of the developmentally disabled. Unpublished manuscript, 1980.

Shontz, F. C. Six principles relating disability and psychological adjustment. Rehabilitation Psychology, 1977, 24, 4, 207-210.

Weed, L. L. Medical records, medical education and patient care: problem-oriented record as basic tool. Cleveland: Case Western Reserve University Press, 1969.

Paper presented at the Annual Meeting of the American Association on Mental Deficiency, 107th, Dallas, Texas May 29-June 2, 1983